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ABSTRACT

This document investigates both immediate and long-term effects of childhood sexual abuse in order to help counselors identify victims and survivors. It is based on a search of the literature on child sexual abuse in the ALICE system in the Alden Library at Ohio University, and the Psychological Literature and Social Sciences Index. Key words used in the searches are identified: child abuse, sexual abuse-children, incest, and sexual abuse-effects. Chapter 1 introduces the topic of the effects of child sexual abuse on victims as both children and adults, providing background information on the prevalence of abuse and the importance to counselors of recognizing its effects. Chapter 2 reviews the literature under the following subheadings: (1) Incidence of Child Sexual Abuse; (2) Immediate Effects of Sexual Abuse on Children; (3) Differences between Male and Female Victims; (4) Effects of Sexual Abuse on Adolescents; and (5) Long-Term Effects observed in Adult Clinical Populations. In Chapter 3 the purpose of the study and the research questions are summarized, and the literature is discussed as to its relevance to the topic, observations, implications, and limitations. In the conclusion, the research questions are answered based upon the literature review, and recommendations for further research are provided, along with suggestions for applying findings to clinical practice. (TE)

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The Effects of Childhood Sexual Abuse on Children, Adolescents, and Adults

A Seminar Paper Presented to the
Faculty of the College of Education
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In Partial Fulfillment
of the Requirements of the Degree
Master of Education

Jenny Byers
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CHAPTER ONE

Introduction

The sexual abuse of children is not a new phenomenon. What is new is that counselors are becoming more aware of abuse as an underlying cause of many of the problems that bring children, adolescents, and adults to counseling. In discussing the incidence of sexual abuse of children, Finkelhor (1984) reviewed several studies in which the number of male victims ranged from 3% to 9% and the female range was from 8% to 28%. These statistics, even at the lowest range, indicate a problem worthy of society's attention. The long-term effects of this abuse are seen in the adult population. Of adult women who were seen in psychiatric settings, Bryer, Nelson, Miller, and Krol (1988) found that 21% had been sexually abused as children. Jacobson (1989) studied psychiatric inpatients and outpatients and found that 19% and 38% respectively had been abused as children. A significant number of adult sex offenders are abuse survivors themselves. One study by Freeman-Longo (1986) found that 80% of convicted sexual offenders were also childhood victims. It is clear that childhood sexual abuse has lon rangining negative effects that may last a lifetime if left unresolved. The abuse itself is often not what brings these adults in contact with helping professionals. Their presenting problems may include among other things, relationship, marital, and sexual difficulties, somatic complaints with no known organic cause, unexplained phobias, depression, and subtance abuse.

Children, adolescents, and adults usually do not disclose instances of sexual abuse. They are powerfully inhibited by feelings of guilt, shame, and fear. It is often up to the counselor or other helper to aid in the client's disclosure of abuse and then begin with them the process of healing. Before

we can do this we need to be aware of the signs and symptoms produced by the abuse. We need to be aware of the effects: why they occur and how to recognize them.

Statement of the Problem

The problem under investigation is what the effects are, both immediate and long-term, of childhood sexual abuse.

Research questions. The following questions were developed to aid in this investigation:

1. What are the immediate effects on the victim, including psychological and behavioral changes?
2. What are the differences between male and female victims?
3. What are the effects on adolescents?
4. What are the long-term effects?
    a. What are some of the presenting problems (not the abuse) that survivors come to counseling with?

Purpose of the Study

The purpose of this study is to help counselors identify victims and survivors of sexual abuse. Counselors can, by increasing their awareness of the effects of abuse, deal more directly with the cause of their client's problems. By helping their client work through the painful issues brought about by the abuse, harmful aftereffects can start to be alleviated. Counselors who are blind to the possibility of a client's abuse, either through ignorance or fear of the topic, will be unable to help a client grow through his or her pain. At best the counselor may contribute superficial and temporary improvement.

Delimitations

This study is limited to the sexual abuse of children by adults. Physical abuse is often seen in conjunction with sexual abuse but isl not discussed. Child victims under the age of 18 are included, and research on adult survivors is included. What is not included is an in-depth discussion of what constitutes sexual abuse, why it occurs, the characteristics of offenders or their own treatment issues. The literature studied is limited to writings in English, and only since 1983 (earlier landmark studies are used when findings are pertinent).

Definition of Terms

1. Sexual abuse: any sexual act including fondling, penetration, and oral sex which is done to a child by an adult, or to a child under the age of 18 by a person significantly older (5 or more years). The apparent absence or presence of force or coercion is irrelevant to this definition (Browne & Finkelhor, 1986). There are many definitions of sexual abuse used by researchers. Finkelhor's is the most clearly defined and is used by several other researchers.

2. Incest: sexual activity (see above definition) with a child by a relative: either by blood, marriage or adoption. A person can also be considered "related" if there is an already existing relationship with the victim. Surrogate fathers and common-law spouses fall into this catagory of incest (Gelinas, 1983).

3. Victim: a child under the age of 18. Since victims are usually girls, the pronoun "she" will be used except where boy victims are specifically discussed.

4. Survivor: an adult who was abused under the age of 18. Most research has studied female survivors, therefor the pronoun "she" is used

except where male survivors are discussed.

5. Abuser: the adult who did the abusing, also called the offender or perpetrator in the literature. Research shows most are males and are either the father, step-father or father figure of the victim. The pronoun "he" is used.

6. Spouse: the non-abusing marriage partner, also called the non-offending spouse in the literature. This is usually the mother of the victim and is refered to as "she".

7. Immediate: a period of time under two years, to be thought of as the initial time period occurring right after the abuse.

8. Long-term: the period of time beyond two years after the abuse to include the lifetime of the survivor.

The Procedure

The Alden Library at Ohio University was searched using the Alice system. The Psychological Literature and Social Sciences Index on CD-ROM were searched. Key words used in all cases were "Child Abuse", "Sexual Abuse-Children", "Incest", "Sexual Abuse-Effects".

Organization of the Study

Chapter One was an introduction to the topic on the effects of child sexual abuse on the victims as children and as adults. Some background was given on the prevalence of abuse and the importance of recognizing its effects for counselors. The research questions addressed were listed. The purpose of the study was discussed, the delimitations of it, and some definitions of terms. The procedure for the study of the literature was presented.

Chapter Two is a review of the literature pertaining to the research questions. The subheadings of the chapter are: Incidence of Child Sexual

Abuse, Immediate Effects of Sexual Abuse on Children, Differences Between Male and Female Victims, Effects of Sexual Abuse on Adolecsents, and Long-Term Effects Observed in Adult Clinical Populations.

In Chapter Three the purpose of the study and the research questions are summarized. The literature reviewed is discussed as to its relevance to the topic, observations and meanings of the literature, and any generalizations and interpretations that can be made. Limitations of the literature are also brought out in this chapter. Then conclusions are made in which the literature is summarized and synthesized so that each research question is answered. The chapter ends with recommendations based upon the conclusions. Suggestions of applications of findings to clinical practice are made as well as recommendations for further research.

CHAPTER TWO

Review of the Literature and Related Research

In this chapter the literature will be reviewed for the effects of child abuse on children, adolescents and adults. Differences between the types of abuse and effects of abuse between boy and girl victims are included. Also included are background discussions of the incidence of sexual abuse, the problems with definitions of sexual abuse, and the incidence of incest.

Incidence of Child Sexual Abuse

An understanding of the number of children who are sexually abused is an important way to begin a look at sexual abuse. Though the reported numbers vary, that they exist at all merits attention. Several studies are presented to give a range of incidence, beginning with a widely quoted researcher, David Finkelhor. In Finkelhor's landmark study of 1979, 796 college students were surveyed to collect data on sexual victimization and incest. Sexual abuse was termed sexual victimization and was defined as any experiences deemed sexual by the subject that involved an older person who by virtue of their age had a substantial advantage of power over the subject. Sexual play or exploration between similarly aged peers was not considered victimization. Victimization was further defined by age as experiences between a child 12 or under with an adult 18 or over, or a child under 12 with someone under 18 but at least five years older, or adolescents from 13 to 16 with adults 10 or more years older. Using these guidelines this study found that of the 796 students, 19.2% of the women and 8.6% of the men reported sexual victimization as a child.

Some other significant findings of this study were that over half of the sexual abuse for girls, and not quite half for boys was found to take place in

the first age catagory of 12 years or younger with an abuser of over 18 years old. The researchers also found that almost half of the abuse among girls was incestuous, and 17% of the boy's abuse was. As for the sex of the abuser, 84% of the boys' abusers were male and 94% were of the girls'. As an aid to determining the overall prevalence of sexual abuse in the general population, Finkelhor stated that the rate may be artificially low because his sample was taken from middle-class college students who were psychologically healthy. He suggests that perhaps the vast majority of sexually abused children are adversely affected by the abuse so that it reduces their educational development and therefore their chances of getting into college.

Another study done by Judith Bergdahl in 1982 surveyed 430 college freshman women and found 35.8% had suffered from sexual abuse before the age of 18. She defined sexual abuse as an adult's use of a child under the age of 18 for sexual gratification using coercion based on cognitive and/or economic advantages over the child. The abuser was almost always male, and 36% of the time he was a family member.

The third study was a 1984 survey by Kercher and McShane of a random sample of Texas drivers license holders. They found that out of 1056 respondents, 7.4% reported sexual victimization as a child. The definition used was a "sexual interaction between a child and an adult or between two minors when the perpetrator is significantly older than the victim or is in a position of power over the victim" (Kercher & McShane, 1984, p. 495). Of the respondents reporting sexual abuse, 82% were women and 18% were men. Of the total sample population this means that 6.1% of the women and 1.3% of the men were sexually victimized.

Salter (1988) reviewed several studies of the incidence of sexual

abuse. Only two were noncollege, nonclinical populations. These two studies found the same rates of abuse; 15% of the women and 6% of the men.

Many studies have been conducted to collect data on the rate of child sexual abuse but the results are disparate. There seem to be several reasons for this. First there is no one accepted definition of sexual abuse, therefore each study creates a definition. Most include fondling, intercourse, and oral-genital contact. Some researchers broaden the definition to include exposure, looking at pornography, and/or verbal sexual enticing. The most general definition of sexual abuse is when an adult uses a child for sexual gratification. A second reason for the disparate rates of abuse may be that the age limit of victims differ greatly from study to study. Some ask for reports of sexual abuse only before the age of 13, or 16, or 18 years of age. The age of the perpetrator is often only stated as "adult". Some researchers add to their definition by stating simply that the abuser is significantly older or may not be chronologically older but for other reasons holds power over the child. A third reason for the disparity between findings may have something to do with the type of samples chosen. They are often skewed and cannot be generalized beyond their population. College students are most often studied, along with psychiatric inpatients and outpatients.

Looking at the incidence of incest is important in understanding the effects of sexual abuse since this subgroup of abuse is usually a very significant portion in each study that makes a distinction. Sexual abuse is most often suffered at the hands of a trusted adult which is traumatic in and of itself. Then add to that a large portion of known abusers come from the victim's own family. The high incidence of intrafamilial abuse (incest) needs to be discussed. Implications for traumatic effects on the child are

based on the betrayal of a pre-existing relationship. The child's ability to trust and to feel secure is damaged.

The following studies found a range of incest rates from 17% to 72% of the populations studied. Finkelhor (1979) found 43% of the abuse of girls' and 17% of the boys' was incest. In Cupoli and Sewell's (1988) study of 1059 children sexually abused under the age of 17, 28% was incest. In Bergdahl's 1982 study, 36% of the sexual abuse was incest. Mian, Wehrspann, Klajner-Diamond, Le Baron, and Winder (1986) studied 125 cases of sexual abuse of children under the age of 6 and found that 60% was incest. Kohan, Pothier, and Norbeck (1987) studied 325 inpatients in child psychiatric units and found 72% incestuous abuse among the abused population. In each of these examples the definition of incest was the same; sexual abuse by a family member. Extended family and step-family members were included except in Kohan's study where incest was only termed "intrafamilial abuse".

Immediate Effects of Sexual Abuse on Children

What happens to a child's inner psyche when she has been sexually abused? The child has been invaded in ways that have breached, if not completely torn down, her physical boundaries and psychological/emotional boundaries. This idea of "traumatic penetration" is part of Jones' (1986) work in which he carries this concept further to the abuse being a threat to the child's own sense of identity and individual being. By first understanding the blow to the child's psyche it is then simpler to see the logic of the first and most intense emotional effects of abuse; namely fear, anxiety, and feelings of helplessness (Gagliano, 1987; Summit, 1983; VanScoyk, Gray & Jones, 1988). The victim's fear may be a fear of the dark, of strangers, fear for her own safety, or fear that the abuse will recur (Gagliano, 1987; Van Scoyk et al., 1988). Specific fears and generalized

anxiety can be manifested in ways that are often seen in children who have been sexually abused. One of these ways is sleep problems and disorders as reported by several studies (Elwell & Ephross, 1987; Mian et al., 1986; Rimza & Berg, 1988; Van Scoyk et al., 1988). These include trouble going to sleep at night, waking during the night, and nightmares. Children do not feel safe after their abuse has been diclosed, even if the abuser is far away or in jail. The perception of the child is what is important and her fears will be reflected in her dreams. An increase in clinginess and dependency behaviors were also noted (Elwell & Ephross, 1987; Mian et al., 1986). These symptoms paint the picture of a child who feels the control over her life is out of her hands. She was shown by someone more powerful than herself that she is weak and ineffectual. The child is and feels helpless and utterly powerless (Summit, 1983).

Anger is also created as a consequence of the abuse. In children it is usually not directed at the abuser but is displaced either inwardly or upon some other person(s). Inwardly directing anger can be seen in children who try to hurt themselves and/or attempt suicide (Adams-Tucker, 1982; Rimza & Berg, 1988; White, Halpin, Strom & Santilli, 1988). Sgroi (1982) believed that victims more often repress their anger. It may be manifested as depression or withdrawal, and/or physical symptoms. Anger turned outwardly is seen as general "acting-out" with: aggressive behavior, behavioral disturbances at school and elsewhere, non-compliant, and anti-social behavior (Freidrich, 1987; Gagliano, 1987; Gale, Thompson, Moran & Sack, 1987). Depending upon the history of the abuse and the manner in which the disclosure was met, the child's anger may be directed toward those she feels failed to protect her.

When a child is sexually abused it may trigger a premature and

inappropriate sexualization of her behavior. This is often the most alarming evidence seen by a parent or caretaker that points to the possibility of a child's victimization. In Salter's 1988 book he states that "Behaviors that are rarely found with any other stressor than sexual abuse, or are found significantly more often in sexual abuse include...specifically sexual symptoms..." (Salter, 1988, p. 231). Gale et al. (1987) also found that inappropriate sexual behavior was among the most common presenting symptoms of sexually abused children under the age of seven. This study compared sexually abused children with physically abused children and a control group of non-abused children. The researchers found that the symptom of inappropriate sexual behavior significantly distinguished the sexually abused group from the other two groups.

These sexual behaviors are often seen in a child's play. Young children will try to "play out" their trauma. Dolls, objects, and maybe even their playmates are incorporated in the sexualized play which may be a specific acting out of the abuse or a more symbolic version. What is obvious to the observer is that the sexual knowledge displayed is inappropriate to the child's developmental level and the acts played out are not part of normal inquisitiveness according to the child's age. In the Mian et al. (1986) study of sexually abused children under the age of six, specific sexual behavior included sexual play with dolls, putting objects in their vagina and/or anus, masturbating, seductive behavior, requesting sexual stimulation and age inappropriate sexual knowledge.

Differences Between Male and Female Victims

The vast majority of research and discourse on child sexual abuse has concentrated on girls as the victims. This is understandable because of the sheer number of cases of abuse that involve girls. Our society has only

recently awakened to the pervasive role of females, whether children or adults, as victims of sexual assault, incest, and domestic violence. The sexual abuse of boys has largely been overlooked by researchers, probably because it seemed to happen so rarely when compared to female abuse. Even if we assume that the incidence of male abuse is only a fraction of all cases of abuse, the subject is still worthy of study for the benefit of the male victims and potential victims.

Incidence. The numbers, however, are in dispute. In reviewing six different studies that compiled data on the abuse of children and then differentiated by the sex of the victim, it was found that the figures range from 11% to 28% of the abused sample being male. (Ellerstein & Canavan, 1980; Pierce & Pierce, 1985; Farber, Showers, Johnson, Joseph, & Oshins, 1984; Rogers & Terry, 1984; Freidrich, Urquiza & Beilke, 1986; Tong, Oates & McDowell, 1987.) In estimating the percentage of the general population of males that have been abused, David Finklehor is a widely quoted researcher. In his book Child Sexual Abuse: New Theory and Research, (1984), Finkelhor compiled data from five studies (three conducted by himself) where surveys were conducted on general samples of men and women. Between 2.5% and 5% of the males had experienced sexual abuse under the age of 13 or before puberty. To produce that percentage across the country, between 46,000 and 92,000 boys would be victimized each year. Finkelhor points out that this number is far above what is actually being reported. He cites the National Incidence Study of Child Abuse and Neglect of 1979 in the United States in which there were 7,600 reported cases of sexually abused boys (17% of all cases). Finkelhor concludes that this type of abuse is extremely underreported.

Maria Nasjleti (1980) presented several possible reasons why boys

would be reluctant to disclose their abuse and thus add to the amount of unreported cases. As boys are socialized in our culture they are taught to be "more aggressive, self-reliant and independent than female children,...[and] are not commonly encouraged to seek help and protection" (Nasjleti, 1980, p.270). We frown upon expressions of dependency, fear, vulnerability, and helplessness in a male. Not only do we discourage these characteristics, we label them as "not masculine". A boy who has been abused may be very frightened by the prospect of letting someone know about it. He would fear being ridiculed for not being able to protect himself and for having to ask someone else for help. Being helpless in a situation and also being a victim are grave threats to a masculine sexual identity that would be forming in middle childhood and adolescence. If the abuser is also a male, then the fear of being labeled a homosexual comes up. This is an issue especially for adolescent boys (Nasjleti, 1980).

Professionals are often not prepared to see boys as sexual abuse victims. The misconception that males cannot be raped shows how our society is biased towards victims only being female. We expect males to be physically strong and able to defend themselves. This stereotype is particularly harmful when adolescent boys have been abused by females. Their disclosure is likely to be met with "disbelief or passive acceptance" (Nasjleti, 1980, p.271).

In a study of differential rates of disclosure between boys and girls, Monaco and Gaier (1988) present five possible reasons why abuse of boys goes unreported. First, the public, and parents in particular, are predisposed to viewing victims as females, not males. Second, our culture allows females to be victims, not males. Summit (1983) also identified this and said we find it easier to believe that girls can be helpless victims,

but not give the same credibility to boys. Third, parents seem to be more apt to talk about sexual abuse with their daughters than with their sons. Therefore sons are not armed with as much information about the possibility of abuse and what it is. Fourth, the perpetrators are most often male and would be reluctant to admit their encounter for fear of being labeled a homosexual. Last, according to Monaco and Gaier sexual abuse of males often takes place in a group with other children. The boy may not know it isn't a game or some other acceptable rationalization given by the abuser.

Differences in abuse. Differences in several aspects of abuse between boys and girls have been discussed in the literature. In the following four studies, six areas of difference between boy and girl victims were observed. Boys showed more signs of physical harm because of the abuse, they were more often abused out-of-doors or in a public place than in their homes, they were younger, they were more likely to be abused by strangers and known non-family members, they were subjected to more oral contact and sodomy as types of abuse and they were often abused by adolescents or juveniles.

Reinhart (1987), in a hospital-based study reviewed the files of 189 boys who had been sexually abused and compared them with an age and race matched group of sexually abused girls. The way boys and girls disclosed their abuse was similar with the exception that more boys' abuse (20% vs. 11%) was unintentionally disclosed. This means the abuse came to the attention of the authorities by someone else: another victim, a witness, or the perpetrator. The male victims were more likely to be abused by adolescents than the girls (19% vs. 8%). For both sexes of victims the perpetrators were mostly unrelated but known people. Only 4% were

strangers who abused the boys. The mean age of the boys was broken down by race and ranged from 4.7 to 6.1 years. The authors called this a younger sample than those previously reported by hospitals. Physical injury was present in 34% of the boys. No comparable data were given for the girls in this study, nevertheless, 34% is substantial. Fifty percent of the boys over age eight had been victims of sodomy.

Pierce and Pierce (1985) studied 205 cases of child sexual abuse and 25 were boys (12%). They found the boys to be younger than the girls: boys' mean age was 8.6, girls' was 10.6 years. There was no incidence of stranger abuse because these cases were all from a state protective services agency and all perpetrators were either family members, relatives, or caretakers. Natural fathers made up 41% of the females' abuse but only 20% of the boys'. As to types of abuse, this study differs from the previous one in that the types of abuse discussed did not separately list vaginal or rectal intercourse therefore the prevalence of sodomy among the boy victims cannot be measured. The differences that did appear between boy and girl victims are that boys were more likely to have been engaged orally (52% vs. 17%) and masturbated (40% vs. 21%) by the perpetrator. Force and threats of force were more often used on the males.

Farber et al. (1984) compared 81 cases of male sexual abuse to 81 cases of female sexual abuse. The cases were compiled over a three year period using a hospital's medical records. The 81 boys and girls were matched for age as in the above study so no age comparison can be made. (The mean age for both sexes was 7.8 years.) The authors did find differences in the type of abuse. Boys were more often engaged in oral-genital contact than girls (43% vs. 16%) and within the male sample sodomy comprised 46.9% of the abuse. For boys the abuse was most likely

to take place out-of-doors. Girls were more likely to be abused by a family member than were boys (53% vs. 39%). It is interesting to note that strangers comprised between 12% and 19% of the perpetrators for both sexes. This study claimed to find no significant differences in many areas including the use of force or threats and the relationship of the abuser to the victim. The authors stated that there was a "relative lack of differences between boy and girl victims [that] suggests that the major factors influencing the sexual abuse of a child are related to variables affecting the perpetrator. Power, not sex, may be the critical factor in sexual abuse" (Farber et al., 1984, p.297).

Rogers and Terry (1984) studied 401 cases of child sexual abuse seen at a hospital. Of the total cases, 101 (25%) were boy victims. Compared to the female victims, the males were younger. Of the boys, 83% were under 12 years old as opposed to 70% of the girls and 26% of the boys were under six. Boys were more likely to have been threatened with physical harm than were girls (51% vs. 37%). Girls were more often abused by a parent or parent surrogate than boys (31% vs. 8%). Abuse by a known, non-family member happened to boys 63% of the time and abuse by strangers happened in 15% of the cases. Girls were usually abused by a family member (52%). Boys were more likely to be abused by a juvenile than were girls (56% vs. 28%). The most common type of abuse of the boys was sodomy (56%).

Differences in effects. Several researchers have investigated the effects of sexual abuse on male and female children. In the following research several differences between male and female responses were observed. Two effects are discussed that are particularly found in young males. One is the tendency to externalize their anger and more often vent aggression towards others. Another effect appears in several articles;

when a boy is abused by a male he will be concerned about his sexual identity. He will question whether he is a homosexual and/or will others think he is?

Focusing on children of adolescent age or younger, Friedrich et al. (1986) studied 85 children, 24 of whom were males (28%). Using the Achenbach Child Behavior Checklist (CBC) they catagorized the children's post abuse behaviors as either Internalizing (depression, anxiety, somatic problems) or Externalizing (aggression, hyperactivity, delinquency). They found that girls tended to show more internalizing behavior and boys more externalizing behavior. The frequency of the abuse and the emotional closeness to the perpetrator were directly related to both extremes of behavior.

Outward manifestations of aggression and hostility are common indicators of and effects of sexual abuse in children (Friedrich & Reams, 1987). This seems to be particularly so for boys. Dixon, Arnold, and Calestro (1978) studied boys abused by fathers and father-figures. They found that boys' hurt and anger seemed to be more easily turned outward, and usually was directed toward the father or father-figure who abused them. Unlike girls who tend to blame both the non-abusive parent as well as the abuser, boys abused by their father rarely placed any blame on their mothers. Thoughts of murdering the father or revenge of some form were common. If left unresolved, this anger and aggression may ultimately lead the boy to act out violently against others or himself. An abused adolescent who is old enough to exercize power over another is at a high risk of becoming an abuser himself. He may get a temporary thrill from the feeling of power and control over someone else, probably a smaller, younger person (Sebold, 1987). Thus the cycle of abuse continues.

Several writers have identified some issues that are of importance to the male victim. Rogers and Terry (1984) addressed behavior changes that they believe are unique to boys and would need to be specifically dealt with in treatment or therapy. They are: confusion and anxiety over their sexual identity, attempts (usually inappropriate) to reestablish their masculinity, and attempts to repeat their victimizing experience.

Sebold (1987) outlined nine catagories of indicators of sexual abuse in adolescent males. He organized these indicators after interviewing 22 therapists who had evaluated and/or treated male victims. The indicators are: (a) Homophobic Concerns: the adolescent male is overly concerned that others not perceive him as a homosexual; (b) Aggressive and Controlling Behavior: the boy will use threatening behaviors in part to prove to himself that he is capable of fending off any more abuse. This is what leads to the aforementioned power plays over other people; (c) Infantile Behavior: the boy regresses in his speech and play behaviors. He will often prefer the company of younger children. This is not so for abused girls, who usually prefer interactions with older children; (d) Paranoid/Phobic Behavior: they will have strong fears that may be related to their homophobia or fear of the abuse being discovered or recurring; (e) Sexual Language and Behaviors: they will have a definite preoccupation with sexual thoughts and behaviors and will often use sexually charged language. This is one of the strongest indicators that any child, of either sex or at any age, has been sexually abused; (f) Dreams: Their dreams will often consist of being chased, punished or isolated by a larger, more powerful person; (g) Body and Image Changes: a boy may be overly neat and clean or just the opposite and not seem to care at all about his appearance. Physical changes of enuresis and encopresis are also very common; (h) Family and Social Indicators: the

most obvious indicator is if there is other abuse taking place in the home. Male children in a family are sometimes overlooked as possible victims when a professional is called in to investigate a family. The male perpetrator will often find it much easier to admit he abused a female than a male, and the male victim may not come forward for reasons already discussed. Investigators need to be more alert to the possibility of male victims in a family; (i) Setting Fires: this was noted by almost all the therapists that contributed to this study. It more commonly appeared as an indicator when the abuser was a female.

Freeman-Longo (1986) wrote in depth about the most far-reaching effect of sexual abuse on a boy. That is the probability that without intervention, he may become an abuser himself. Most research in this area has been done on adult male sex offenders. It has been found that when the offenders themselves were sexually abused (usually in adolescence), their offenses are a replication of their own abuse, an anger reaction to their abuse, and/or a modeling of their victimization. Intense feelings of anger, hurt, and frustration are characteristic in the victim and will erupt in an adolescent or adult male into acts of aggression against others. As adults, they often feel hatred against their abuser and want to retaliate against him, even if their abuser is dead or at least no longer a threat to them. The offenders will still feel a lack of power in their lives and believe their abuser still has power over them. Their assaults can be seen as trying to recapture their own power and control.

Effects of Sexual Abuse on Adolescents

In this section we review the literature on the effects of sexual abuse as observed in the adolescent population. The adolescent years involve different developmental needs and therefore a wider range of psychological

and behavioral effects are noted. The effects on the younger child are still applicable but there are added concerns and behavioral manifestations for the adolescent. For example fear and anger are effects for both children and adolescents, but running away is rarely seen in younger children as a response to being sexually abused. However it is developmentally appropriate for the more independent adolescent.

James and Nasjleti (1983) presented a developmental perception of adolescent responses to incest. The abuse has usually started before the onset of puberty. By the time the child has become an adolescent, it has evolved to include intercourse. Add to this increased pressure the developmental needs the victim is experiencing; searching for her own sexual identity, separating from her parents, becoming independent, and building peer relationships. The adolescent becomes more aware of the wrongness of the abuse and her exploitation. She gets angry, or if her anger has already surfaced, then it gains intensity and often leads to disclosure. Unfortunately, the victim is frequently not believed. With incest victims, they may attempt to disclose once or twice and then give up trying (Bentovim, Elton, Hildebrand, Tranter & Vizard, 1988). According to Faller (1988) the adolescent's motives are often questioned if they disclose. Others will attribute their allegations to trying to get revenge on someone or to try to cover up their own sexual activity.

Several effects seen particularly often in adolescent victims are caused by the need to escape the abuse. Running away, abusing drugs and alcohol, attempting suicide or even getting pregnant are ways to escape (Bentovim et al., 1988). Dembo et al. (1987) theorized that illicit drug use by sexually abused adolescents is an attempt to self-medicate their inner pain and mentally escape the abuse. As for a link between sexual abuse and

runaways, the following two studies are of note. In a study of 144 adolescent runaways, McCormack, Janus, and Burgess (1986) found that 73% of the females and 38% of the males had been previously sexually abused. In a study with complimentary findings, Lindberg and Distad (1985) surveyed 27 adolescents with known incest histories and 17 (63%) were runaways.

Another catagory of effects can be described as self-destructive. These arise out of feelings of depression and low self-esteem. Lindberg and Distad (1985) believed that self-destructive behaviors were a logical and predictable response by teenagers to sexual abuse, particularly incest. As self-destructive behaviors they included running away, substance abuse, suicide attempts, self-mutilation, and promiscuity. They interpreted these as attempts to reduce stress in the victim's life or to assert some control over their helplessness. Dembo et al. (1987) believed that adolescents who were sexually abused suffered from self-derogation (negative self-esteem) and therefore were more likely to use illicit drugs as a response. They studied 145 adolescent detainees in a juvenile detention center and compared those who had been sexually abused with those who had been physically abused. Of their sample 46% had been sexually abused and showed significantly higher measurements of self-derogation and also reported more illicit drug use than those not sexually abused.

Eating disorders could be included in the catagory of self-destructive behaviors but will be listed here with promiscuity and prostitution. These are all observed by researchers as adolescent sequelea to sexual abuse (Bentovim et al., 1988; Faller, 1988; Paperney & Deisher, 1983; Westen, Ludolph, Misle, Ruffins, & Block, 1990). Eating disorders in adolescent girls who have been sexually abused is viewed as a way of denying their sexuality and reflects their low self-esteem and poor body image. It may also be an

attempt to stop ongoing abuse, or as a defense against new occurrences. Promiscuity and prostitution, on the other hand, may be a way of repeating learned behavior from the abuse (Bentovim et al., 1988). An adolescent with low self-esteem and a poor self-image may see sexual behavior as a way of relating to others. Instead of denying her sexuality she goes to the other extreme of becoming a sex object. Most of the literature in this area looks at females, however one study of adolescent male prostitutes showed that 43% had been previously sexually abused (Paperney & Diesher, 1983).

Long-term Effects Observed in Adult Clinical Populations

The studies of adult survivors of childhood sexual abuse reflect negative long-term effects. The majority of the research looks at samples from clinical populations. What follows is a review of eight such studies to note the incidence of childhood sexual abuse or incest, and the effects where available. They are presented in order of the size of the sample used.

In Jacobson (1989) the sample was of 131 psychiatric inpatients and outpatients of a large county hospital. Of the total sample, 31 subjects or 23.6% had been sexually abused as a child. She compared inpatients to outpatients and found more inpatients had a history of abuse than outpatients (38% vs. 19%).

Craine, Henson, Colliver, and MacClean (1988) interviewed 105 female state hospital psychiatric patients and found that 51% had been sexually abused as a child or adolescent. The six most common symptoms of sexual abuse identified in this sample were, (a) compulsive sexual behavior, (b) chemical dependency, (c) sadomasochistic sexual fantasies, (d) sexual identity issues, (e) chronic fatigue, and (f) loss of interest in sex. The authors suggested that the incidence of child sexual abuse is higher in a psychiatric inpatient population than in the general population. The

implication was that childhood sexual abuse "may be a significant factor contributing to psychpathology severe enough to require hospitalization" (Craine et al., 1988, p.303).

Briere and Zaidi (1989) reviewed the charts of 100 nonpsychotic female patients seen in a psychiatric emergency room. Of these charts, 50 were chosen randomly and 50 were from patients who had been specifically queried about sexual abuse. Of the specific query sample, 70% reported sexual abuse compared to 6% of the random sample. In the sexually abused subjects, a higher frequency of suicidal ideation and attempts was observed along with a larger amount of substance abuse, sexual difficulties, and multiple psychiatric diagnoses. It was also interesting to note that of the sexual abuse, 74% was incestuous.

Hartman, Finn, and Leon (1987) did a study of 87 women in group therapy. Of this sample 70% had been abused and of those, 50% were incestuously abused. The researchers then compared the effects on the incestuously abused group to the effects on the extrafamilially abused group. They found that the incest victims suffered from a higher level of anxiety currently and at the time of the abuse, and a higher level of depression. The authors found a correlation between a younger age of onset of the abuse, a greater number of sexual contacts that made up the abuse, and a greater number of additional abusive incidents over the lifetime with current higher levels of distress. Incest victims were found to have a greater probability to experience further sexual abuse, had more psychiatric hospitalizations, and suicide attempts.

Briere et al. (1988) included men in his study of 80 outpatient clients of a crisis counseling program in a community health center. This research compared 40 subjects who reported childhood sexual abuse (20 men and 20

women) with 40 who reported no sexual abuse (20 men and 20 women). A difference according to sex was that the female victims were abused to a later age than the men, and their abuse consisted of more incidents. There were some significant similarities between the sexes; the age of onset of abuse was virtually equal, and the abuse was incestuous for half of the subjects regardless of sex. The abused group as a whole scored higher than the nonabused group on measurements of dissociation, anxiety, depression, anger, and sleep disturbances.

Bryer et al. (1987) surveyed 66 female inpatients in a private psychiatric hospital. The number of patients who were found to have been sexually abused was 29 or 54%. Of these 52% were incestuously abused. The authors believed that this was a higher rate of sexual abuse than previously reported in the literature. This was perhaps due to fact that the information came from direct questionnaires rather than chart reviews. They differentiated characteristics of the abused and nonabused groups. Abuse victims had more psychotic or psychotic-like symptoms, more borderline diagnoses, and more suicide attempts.

Walker et al. (1988) collected data from a medical population to identify a relationship between chronic pelvic pain and a history of childhood sexual abuse. The data were collected via examinations and interviews of 55 women. Sexual abuse that occurred before the age of 14 turned up in 41% of the sample. These women were more likely to suffer from a sexual dysfunction than the non-abused group. They also had a higher risk of major depression and drug abuse. The authors saw a link between chronic pelvic pain and childhood sexual abuse because in their sample, 25 women were picked because they had this complaint and of those, 64% had been abused. Walker et al. speculated that the physical pain may be a form

of the subject's psychological pain and may also be used as a way to avoid sexual contact.

Lowery (1987) compiled 14 cases of adult incest survivors who were patients in the psychiatric unit of a hospital. The following manifestations of childhood incest were part of her observations of this group: sexual dysfunctions, self-destructive behavior, emotional and physical abuse toward children, impulsive behavior, marital problems, difficulty sustaining intimate relationships, depression, poor self-esteem, promiscuity, somatic complaints, feelings of detachment, lack of trust, feelings of powerlessness, needing always to care for others, difficulty with authority figures, and difficulty in parenting.

Two authors, Denise J. Gelinas and Gerald S. Ellenson, have written articles that contribute to the understanding of the long-term effects of child sexual abuse by creating conceptual frameworks of effects. In these two models the lists of symptoms and types of presentations of an adult survivor are organized into meaningful catagories. Gelina's (1983) work was written about incest survivors and is included here because of the high rate of incest within the general phenomenon of sexual abuse noted earlier in this chapter. The symptoms and effects she discusses are also found in extrafamilial abuse. Ellenson's (1985) model is not solely about incest survivors but includes those who were abused by a trusted adult, not necessarily a relative.

There is a wide range of symptoms described in the literature that Gelinas (1983) reviewed. A large overlap exists between these symptoms and those presented earlier in this chapter. The most frequently reported problems of adult survivors of incest were, (a) sexual dysfunctions including orgasmic dysfunctions and difficulty with sexual contact, (b)

promiscuity, prostitution and/or running away, (c) history of adolescent pregnancy, (d) depression, (e) intense guilt, (f) poor self-esteem, (g) self-destructive behavior including substance abuse, (h) anxiety, (i) somatic complaints such as headaches and nausea, (j) learning difficulties, (l) increased risk of physical and emotional abuse towards children, and (m) increased risk of continued incestuous abuse of their children by their spouses. Gelinas believed this large scope of problems could be accounted for by three underlying negative effects: chronic traumatic neuroses, continuing relational imbalances, and increased risk of intergenerational incest.

The first catagory is chronic traumatic neuroses. The sexual abuse experienced as a child is a trauma and the aftereffects are similar to those of survivors of other traumas. Gelinas chooses not to use the term "Post Traumatic Stress Syndrome" but prefers instead the older term of "traumatic neuroses". These effects are experienced by incest survivors at any time after the abuse has happened. Most come about after the experience has been denied or repressed for many years. Gelinas discussed these effects as seen in a person after disclosure of the abuse while she is in treatment, before disclosure, and the secondary elaborations that occur when the traumatic neuroses have not been treated.

After disclosure and during treatment the client will relive much of the feelings that surrounded her abuse. These feelings are very intense and are what she felt as a child during and after the abuse. Fear is the predominantely reported feeling along with helplessness and powerlessness Before disclosure when these intense feelings are repressed, the memories themselves are sometimes not recalled. This is a form of denial. In cases where the memories are there, denial may take the form of minimizing the

importance of the abuse in the survivor's life. They will dissociate themselves from the trauma when it was happening and throughout their lives. An extreme example of dissociation is induced self-hypnotic anesthesia as in the case of a woman Gelinas writes about who could completely numb any part of her body. This ability was first used as a psychic defense against the incest and physical abuse she suffered as a child. After the abuse has ceased, a survivor will still dissociate at times of stress or when abuse related feelings or memories are triggered. A survivor would act confused and feel that she was not "all there".

Repetitive intrusions of the traumatic event(s) will happen in spite of all the energy a survivor invests in repression and denial. These can be recurrences in thought such as nightmares, hallucinations, recurrent unbidden images, and recurrent obsessive ideas. Emotional recurrences are exemplified by panic attacks or weeping episodes that are not consciously linked to the abuse. Behavioral reenactments are compulsive verbalizations about the abuse, and recurrent expressions of it through gesture, movement or artistic productions.

Secondary elaborations of the neuroses evolve as the trauma goes untreated. The symptoms are the reasons survivors will seek help. The most widely seen is chronic depression with guilt, poor self-esteem, feelings of powerlessness, learned helplessness, and suicidal ideation. Other problems are expressions of heightened anxiety including phobias, feeling vulnerable, irritable, substance abuse and impulsive behavior. These secondary elaborations are often precipitated by developmental triggers or milestones that have some similarity to the abusive events in childhood. Most of these triggers are sexual, the most common being simply the development of the survivor's own adult sex life.

The second catagory of underlying negative effects is that of relational imbalances. The effects of the sexual abuse itself are joined by the effects of growing up in an incestuous family system. The betrayal of trust, the exploitation of a child for an adult's gratification, the relational imbalances throughout the family become a part of the child who grows up. She is stunted in her own development and will tend to relive and recreate the relational imbalances she grew up with. Thus she has problems maintaining intimacy with friends or family. She was "parentified" as a child to take care of her parents needs before her own and as an adult will continue to take responsibility for others needs to the exclusion of her own. Her relationships will not be reciprocal. A survivor will tend to marry a man who is needy, immature and demanding. Her family of origin will continue to cause problems because they still feel a right to her and she still feels responsible to and for them. If she has children, parenting will hold many problems. With her low self-esteem and feelings of helplessness and guilt she will find it difficult to discipline or set limits for her children. Emotionally she will feel depleted and overwhelmed by her children. Feeling depleted and perceiving herself as a failure she may distance herself emotionally from her children.

The third negative effect is the intergenerational risk of incest. The adult survivor is at a higher risk of being involved in further incest by being the mother of a victim. Since she is apt to marry a needy man, and then pull away from her children and possibly her husband, the stage is set for the same relational imbalances she experienced as a child. If there is a daughter present and she is "parentified" into taking care of the needs of her parents she will be vulnerable to sexual abuse by her father. This scenario also requires the mother to be avoidant of any reminders of her own abuse

so she will not notice its recurrence.

In the second conceptual framework, Ellenson (1985) proposed a syndrome to help detect a history of childhood sexual abuse in adults. He compiled a group of symptoms from conducting mental status examinations with female clients. He delineated the symptoms that were present only in women who had been sexually abused as a child. He uses the term incest but defines it broadly to include trusted adults outside of the family. The list is helpful because the symptoms are specific in their detail. This specificity aids Ellenson's claim that these symptoms have not been observed by him in any clients without a history of childhood incest. There is much in common between this model and the previous one, but Ellenson's detailed list could be especially useful to counselors in helping determine if a client has a history of sexual abuse.

The syndrome consists of two groups of symptoms: thought content disturbances and perceptual disturbances. All symptoms seem to represent "a disguised recall of painful childhood experiences" (Ellenson, 1985, p.532). Thought content disturbances include recurring nightmares about: catastrophes that endanger the client and/or her family members, children being harmed or killed, client and/or family members being chased by attackers, or scenes of death and/or violence. Thought content disturbances may also be recurring dissociations as in sudden feelings that ones child is a stranger, or a dissociation from the past as if it belonged to someone else. Persistent phobias are the last part of this catagory and they would take the form of an intense dislike of being alone and of being in physically vulnerable situations.

The second group of symptoms are those of perceptual disturbances. These are: (a) recurring illusions of a frightening feeling of the presence of

an evil or malevolent being in the home, or a frightening feeling of being entered by such a being: (b) recurring auditory hallucinations of hearing a child or other person calling out to the client, hearing sounds of an intruder, or hearing booming sounds like a dungeon door slamming or an explosion: (c) recurring visual hallucinations of objects or figures moving in one's peripheral vision, seeing furtive shadows or shadowy figures at home, or seeing a dark, featurless, silhouetted figure when in bed at night: (d) recurring tactile hallucinations of physical sensations that range from a touch to being pushed or thrown.

The author believed that the presence of seven or more symptoms is predictive of a history of childhood sexual abuse. These symptoms are unfortunately not readily reported by clients because they fear they will be thought of as "crazy". In other words, if the client is not asked about the occurrence of these symptoms specifically, she will probably not volunteer that she has any of them. An atmosphere of relaxed acceptance must be present in the interview for the comfort of the client. It is recommended that the least "crazy" symptoms are explored first before the more scary ones, such as hallucinations. Those are best left to later in the interview after some feelings of trust have developed towards the interviewer.

Summary

In this chapter we reviewed the literature on the effects of sexual abuse. The different rates of incidence of abuse were dealt with at the beginning of the chapter. Nonclinical studies were reviewed and a range of childhood sexual abuse among men was from 1.3% to 8.6%. The range of incidence for women was from 6.1% to 35.8%. Finkelhor's study in 1979 is the most commonly cited in the literature and gives rates for childhood sexual abuse as 19.2% of females and 8.6% of males. Literature was

reviewed for the immediate effects on children and found fear, anxiety, and helplessness common. Behavioral symptoms stemming from those effects were sleep problems, nightmares, and clinginess. Anger was another emotional effect that could be turned inwardly or directed outwardly. Sexualized behavior was another effect and seen in a child's sexualized play, which included acts with herself and/or others, and age-inappropriate knowledge about sex.

Differences between male and female victims found a range in the literature of 2.5% to 17% male victims found in studies of nonclinical populations. The range seen in clinical studies was from 25% to 28%. Several reasons for the underreporting of males were given. One is the cultural expectations of society that boys are not supposed to admit weakness and that they should be able to protect themselves. This predisposes people to not believe that boys can be victims. Boys also internalize those expectations so they are reluctant to disclose abuse. A second explanation is the fear a boy will have of being labled a homosexual since the majority of abusers are males also. Differences in abuse were reviewed and found to be that boys are younger victims than girls, more apt to be abused by nonfamily members and by younger abusers. Differences in effects were found to be that boys more often externalized their anger than girls, experienced fear and confusion about their sexual identity, and were more at risk to repeat the abuse on others.

The literature was reviewed for effects on adolescents and common themes found were running away, substance abuse, depression, and promiscuity.

Long-term effects were found in studies of clinical populations of adults. Some common signs of childhood sexual abuse emerged as sexual

difficulties, suicidal ideation, substance abuse, dissociation, anxiety, and depression. Following this two frameworks were discussed to help understand long-term effects and how they might present in counseling. The first was a conceptualization of childhood incest as a trauma resulting in neuroses, continued relational imbalances, and an increased risk of intergenerational incest. The second framework suggested a syndrome to detect a history of childhood sexual abuse. Two groups of symptoms were presented: thought content disturbances and perceptual disturbances.

CHAPTER THREE

Discussion, Conclusions, and Recommendations

Summary

The purpose of this study was to help counselors identify victims and survivors of sexual abuse by identifying and describing the effects of abuse as found in the literature. The research questions were:

1. What are the immediate effects on the victim, including psychological and behavioral changes?
2. What are the differences between male and female victims?
3. What are the effects on adolescents?
4. What are the long-term effects?
    a. What are some of the presenting problems (not the abuse) that survivors bring to counseling?

Discussion

The first research question asked "What are the immediate effects of child sexual abuse?" The literature did not often attempt to directly answer this question. A large portion of the research has been directed at identifying the demographics of abuse victims, their families, and the abusers. Recently more literature is available that stresses finding the effects of sexual abuse by compiling lists of signs and symptoms. These studies show that the psychological effects on a child can be very harmful to their developing ego and identity. The invasion and use of a child for an adult's gratification leaves the child feeling helpless, powerless, and unsafe. The findings yield a varied list of symptoms a child may exhibit after having been abused or during ongoing abuse. Most of the symptoms can have causes other than sexual abuse with the possible exception of sexualized behavior such as sex play with toys and peers, and excessive

masturbation. A person who works with children or cares for children needs to be aware of the wide gamut of possible symptoms. Any of the symptoms warrant attention, especially premature and inappropriate sexualized behavior.

The writings on effects fell into two types: those that were empirical studies aimed at identifying effects, and those that were not empirical but were case observations of clinicians who worked with sexual abuse victims. The empirical studies sampled both clinical and nonclinical populations. All subjects were those who had previously been identified as victims but not all were in treatment. This helps generalize the findings, for negative effects were found in samples of children who were identified as "needing treatment" and those who were not. This is in contrast to adult samples discussed below in which most of the findings come from populations already in treatment for one reason or another. Thus it is difficult to isolate sexual abuse as a sole or at least major cause of their problems. In the research on children reviewed for this paper, the methodology varied. Samples came from different sources including treatment populations, telephone disclosures, child protection agency rolls, and hospital medical examination charts. The number of subjects in the samples varied from 8 to 125 but the majority were under 40. In identifying effects some used behavior checklists, others used emotional assessments or unstructured clinical observation. The empirical and nonempirical writings supported each other. Both types found similar effects. The empirical research helped identify the effects and the nonempirical research helped in understanding why they occur, how they are manifested, and how they might be effectively addressed by helping professionals.

A generalization can be made that there are numerous negative

effects, both psychological and behavioral due to child sexual abuse. The data come from a cross section of demographics: race, socioeconomic level, family configurations, and type of abuse. It is important to include more males in the samples to allow generalization of these effects to that population. This shortcoming is beginning to be rectified and is discussed in the next research question.

In summary, the immediate effects of childhood sexual abuse that were found in this review of the literature are: feelings of fear, helplessness, and powerlessness, sleep disorders, increased dependency behaviors, anger, and sexualized behavior.

The second research question asked "What are the differences between male and female victims?" The vast majority of the literature on child sexual abuse does not include significant numbers of males, nor does it compare effects between the sexes to determine if there are any differences. From the few studies that have been done in this area, the findings are that boys may be differently affected by abuse, and their experiences of abuse may vary from that of girls. The problems boys have include a more intense struggle with sexual identity questions than girls because of the fact that most of the abusers are male too. Also boys may be expected to show their anger more outwardly and aggressively than girls. The problem of underreporting of male sexual abuse was eloquently articulated by some authors. Practitioners were admonished to be aware of males as victims and the possibility of some sex specific reactions to abuse. A useful source of information on this question was clinical observations and experiences.

The methodologies used in this literature were more limited than the general literature on sexual abuse. More clinical, in-treatment populations

were used which weakens the possibility of generalizing the findings to all boys who were abused. As in the studies that were reviewed to answer the first research question, the literature that talks about boys is mostly geared towards demographic data. Six empirical studies were reviewed and of these, one was specifically aimed at identifying effects of sexual abuse. This study compared responses between the sexes but this was not its' primary purpose. The numbers of subjects in the empirical studies ranged from 25 to 189 with most above 50. The larger samples may help to generalize the findings. However, a limitation noted by this writer was that although male and female victims were compared to each other, there were no instances of a study comparing abused boys to nonabused boys.

A study that mixed features of empirical data gathering and organizing with clinical observations was very informative. This work compiled the responses of 22 therapists to a survey on the effects of sexual abuse seen in boy victims in treatment. The validity of this study would have been enhanced if the number of victims seen were listed. A limitation was that no control was used. It would have been helpful to compare the symptoms of sexually abused clients with nonabused clients.

The nonempirical studies once again proved informative. Case studies, anecdotal evidence and clinical observations added significantly to understanding the effects of sexual abuse on boys. Although these were all from clinical experiences, the way they supported each others' findings adds validity to them. Their observations of effects may be generalized to a clinical population but not to nonclinical ones.

In summary, the differences in effects on boys that were found in this review of the literature are: boys externalize their anger more than girls and will be anxious about their sexual identity because of the abuser most

often being a male.

The third research question asked "What are the effects on adolescents?" In reviewing the literature it became clear that the negative effects begun in childhood extended into adolescence. However, the teenagers' problems have more potential for harm to themselves and to others.

Empirical research directed towards the effects of child sexual abuse on adolescents was plentiful. This may be because outward manifestations such as running away, substance abuse, suicide attempts, and promiscuity are more attention-getting and more easily studied. Two articles went beyond quantifying symptoms. They presented a theoretical framework to understand what triggered the effects and did empirical studies that supported them. All of the empirical studies that were reviewed used samples from clinical populations. These populations were from the more problematic end of the effects spectrum. They included subjects in an inpatient adolescent unit in a hospital, the custody of social service agencies, a runaway shelter, a juvenile detention center, and a residential facility for emotionally disturbed adolescents. The high degree of disturbance in these samples yields two observations: one is that the effects of childhood sexual abuse on adolescents are extremely damaging and dangerous, and two is that it is difficult to generalize from these samples to the general population of abused adolescents.

A generalization that can be made is that a large number of adolescents who abuse drugs, run away from home, and exhibit other self-destructive behaviors, have also been sexually abused as children. A generalization that cannot be made is that most teenagers who have been sexually abused will show those symptoms.

The numbers in the samples ranged from 27 to 145 with most having over 50. This is comparable to the research in general on sexual abuse victims. The studies seemed to have more internal validity than studies of children that were reviewed because they included control groups of nonabused adolescents within the particular clinical setting. A limitation of the research was that it was aimed at looking at behavioral signs of sexual abuse. Only one study measured any emotional effects.

The fourth research question asked "What are the long term effects of childhood sexual abuse?" There was a large amount of research available on adult female survivors. Nonempirical writings stressed the many long lasting effects that they experience. These are translated into the presenting problems that counselors and other professionals see. These articles dealt mainly with incest and women. They were helpful in that they explored issues that arise in the lives of functioning women, not only from severely disturbed clinical populations.

The empirical studies covered clinical populations. Most drew their samples from psychiatric inpatients and outpatients. Two studies compared a clinical sample to a nonclinical sample of survivors but did not discuss long-term effects specifically. All but two studies included exclusively female subjects. Fortunately the two that did include male survivors were well structured studies that included control groups and whose samples held equal numbers of men and women. This helps to generalize their findings and their findings echoed those of the other studies.

Observations that can be made from these studies are that large portions of psychiatric patient populations have a history of childhood sexual abuse. Another generalization that can be made is the same as the one for adolescents: effects such as substance abuse, sexual dysfunctions,

suicide attempts, and depression are experienced by many adult survivors of sexual abuse. It cannot be generalized that most all survivors have these signs because of the small number of studies with nonclinical samples.

The area of somatic complaints as symptoms was discussed by some authors but only one study was found on the subject. This study linked chronic pelvic pain, a common complaint of women, to childhood sexual abuse. Other studies included somatic complaints such as migraine headaches and nausea in their lists of symptoms but did not explore them further.

Limitations

The literature reviewed for this paper was limited to that which addressed the effects of childhood sexual abuse. The effects and occurrence of physical abuse are often similar to sexual abuse but this topic was not discussed. For background, a discussion of the incidence of sexual abuse was included along with the problems found in the literature of disparate rates of incidence and definitions. Incest was looked at as a subgroup of sexual abuse. Rates of incidence of incest were reported whenever they were available in the literature.

The literature available for review varied according to topic. The incidence of child sexual abuse has been widely researched but specific effects on children have not received much attention. When they were mentioned, emotional and behavioral effects often came in on the tail end of empirical research studies. The literature on boy victims was even more limited. Empirical data on the incidence and type of abuse suffered can be extracted from studies that included both sexes but research into the effects on boys has barely begun. Fortunately several writers have contributed substantial non-empirical findings and they were utilized in

this paper.

Limitations in the adolescent and adult literature were similar. Most of the populations studied were clinical and often limited to acute behavioral signs of abuse while ignoring more indepth study of emotional effects. The adolescent samples did include some males, but the adult studies were almost exclusively female. This was especially noted in the nonempirical writings that in the other topic areas had been instrumental in filling in the gaps left by the empirical data.

Some problems faced by women that have been linked to childhood sexual abuse were not part of this paper. There is literature available that looks at multiple personalities, borderline personalities and characteristics, eating disorders, and alcoholism among women survivors.

Other issues of sexual abuse were not included in this paper. The link between male victims and later abuse of others was not explored in depth. Many studies have been done on abuser characteristics but were not reviewed. Theories about the causes of sexual abuse, the characteristics of the families of victims, and the effects on the families were not discussed. Treatment models and modes of therapy for victims were not included. There are many other important aspects of abuse, but this paper was limited to effects in order to do that topic justice.

Conclusions

1. The effects of sexual abuse on children include feelings of fear, helplessness, powerlessness, and anger. These may be seen behaviorally as increased clinginess, nightmares and other sleep disturbances, sexualized behavior, and either outward or inward manifestations of anger.

2. Boys are sexual abuse victims and professionals must be aware of this. Effects of particular note in boys are that they show their anger more

externally and aggressively, they will suffer confusion and anxiety about their sexual identity, and if left untreated may grow up to abuse others.

3. The effects of sexual abuse on adolescents are seen more in the behavioral realm though they stem from the same feelings that children have. Behavioral signs include running away, substance abuse, self-destructive acts, and promiscuity. Adolescents are often motivated by anger and the need to escape.

4. Long-term effects of sexual abuse are many and varied. Female survivors often experience negative effects such as depression, suicide attempts, sexual dysfunctions, relationship problems, and substance abuse.

5. Children, adolescents, and adults very often do not disclose their abuse but do end up in contact with helping professionals for reasons relating to their abuse.

6. Depression and thoughts of suicide were reported to some degree in all age groups of victims.

7. Substance abuse was the most often reported sign of sexual abuse among adolescents and adults.

8. Incest makes up a large portion of sexual abuse and appears to contribute to more long lasting, harmful effects.

Recommendations

Recommendations for further research. Several recommendations are made for further research based on the review of the literature:

1. Empirical studies need to be conducted on nonclinical populations in all age groups. Comparisons of abused and nonabused subjects' psychological and behavioral problems would greatly enhance the study of the effects of sexual abuse. This would also help in the study of the incidence of sexual abuse to look at more general population samples.

2. Empirical research into the differences between male and female victims is needed. Male victims and survivors of all ages need to be studied for their own sex-related effects. Control groups of nonabused males should be included.

3. Emotional and psychological effects should be given more attention in research projects. Though it may be easier to identify and measure behaviors, a deeper understanding of the effects of sexual abuse on a victim's personality and self-image is lacking.

4. Further exploration into a link between child sexual abuse and suicides or suicide attempts is needed.

Recommendations for field applications. Following are recommendations for field applications based on the review of the literature:

1. People in a position to notice, e.g., nurses, doctors, teachers, parents, social workers, counselors, psychologists, psychiatrists, and parents, need to be aware of the signs and symptoms of sexual abuse. They also need to be equipped with respectful and effective ways of helping people of all ages disclose their abuse.

2. Helping professionals need to be cognizant of boys and men as victims and survivors of sexual abuse.

3. Since substance abuse was the most often reported sign of sexual abuse in adolescents and adults, clinicians should explore the possibility of a history of sexual abuse with their clients who were or are substance abusers. Treatment programs for substance abusers could incorporate issues relevant to sexual abuse victims.

The significance of this review of the literature is that it all too clearly illustrates the devastation caused by sexual abuse. The effects of

this type of abuse cause immediate psychological harm to the victim. Then as the victim grows up and goes through life, the pain and damage of the abuse becomes apparent in many ways. All too often the abuse is not disclosed and the victim continues to suffer, feeling isolated and even "crazy". Without therapeutic intervention and treatment it seems that the survivor's life will often be problematic from failed relationships and depression, to substance abuse and suicide attempts.

Counselors and other helpers must be aware of the existence of sexual abuse and of its consequences. When we suspect a person has been abused, we must explore that possiblity and be able to deal with the victim's trauma or refer them to someone who can.

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